

| 2017 Medicare Advantage Plans | Summary of Benefits Table (Iberia Parish) | | |
|--|---|---|---|
| | Humana Gold Plus | HumanaChoice | HumanaChoice |
| Contract ID/Plan ID | H1951-042 | R5826-011 | R5826-068 |
| Organization Name | Humana Health Benefit Plan of LA | Humana Insurance Company | Humana Insurance Company |
| Type of Medicare Plan | Local HMO | Regional PPO | Regional PPO |
| Monthly Consolidated Premium (includes part C & D) | \$0 | \$77 | \$0 |
| Health Plan Deductible | \$0 | \$1,000 annual deductible | \$1,000 annual deductible |
| PCP Co-pay | \$15 | \$15 | \$10/ \$35 |
| Specialist Co-pay | \$15- \$45 | \$15- \$50 | \$10- \$35/ \$50 |
| ER | \$75 per visit (always covered) | \$75 per visit (always covered) | \$75 per visit (always covered) |
| Ambulance | \$265 or 20% | \$265 or 20% | \$265 or 20% |
| Skilled nursing | \$0 for days 1 through 20 \$164.50 for days 21 through 100 | \$0 for days 1 through 20 \$164.50 for days 21 through 100 | \$0 for days 1 through 20 \$164.50 for days 21 through 100 |
| Inpatient Hospital | \$215 for days 1 through 8 \$0 for days 9 through 90 \$0 for days 91 and beyond | \$275 for days 1 through 7 \$0 for days 8 through 90 \$0 for days 91 and beyond | \$195 for days 1 through 6 \$0 for days 7 through 90 \$0 for days 91 and beyond |
| Annual Drug Deductible | \$200 | \$400 | Drugs not covered |
| Additional Coverage Offered in the Gap | \$6- \$100 and/or 29%- 51% | \$6- \$100 and/or 25%- 51% | Drugs not covered |
| Chemo Drugs | 20% | 20%/ 19%- 25% | 20%/ 30% |
| Out-of-Pocket Maximum | \$6,700 | \$6,700/ \$10,000 | \$6,700/ \$10,000 |

| Summary of Benefits Table (Iberia Parish) | | | | |
|--|---|--|--|--|
| Medicare Advantage Plans | HumanaChoice | Peoples Health Choices Gold | AAA0 Vantage Standard | AAA1 Vantage Premium |
| Contract ID/Plan ID | R5826-078 | H1961-017 | H5576-017 | H5576-018 |
| Organization Name | Humana Insurance Company | Peoples Health | Vantage Health Plan | Vantage Health Plan |
| Type of Medicare Plan | Regional PPO | Local HMO | Local HMO | Local HMO |
| Monthly Consolidated Premium (includes part C & D) | \$47 | \$0 | \$35 | \$151 |
| Health Plan Deductible | \$1,000 annual deductible | \$0 | \$350 Out-of-network | \$350 Out-of-network |
| PCP Co-pay | \$15/ 30% | \$10 | \$15 0%- 20% | \$10 0%- 20% |
| Specialist Co-pay | \$25- \$50/ 30% | \$40 | \$45 0%- 20% | \$40 0%- 20% |
| ER | \$75 per visit (always covered) | \$75 per visit (always covered) | \$75 per visit (always covered) | \$75 per visit (always covered) |
| Ambulance | \$265 or 20% | \$220 | \$250 | \$250 |
| Skilled nursing | \$0 for days 1 through 20 \$164.50 for days 21 through 100 | \$0 for days 1 through 20 \$160 for days 21 through 100 | \$0 for days 1 through 20 \$164 for days 21 through 100 | \$0 for days 1 through 20 \$164 for days 21 through 100 |
| Inpatient Hospital | \$275 for days 1 through 7 \$0 for days 8 through 90 \$0 for days 91 and beyond | \$195 for days 1 through 7 \$0 for days 8 through 90 | \$325 for days 1 through 5 \$0 for days 6 through 90 | \$275 for days 1 through 5 \$0 for days 6 through 90 |
| Annual Drug Deductible | \$400 | \$0 | \$0 | \$0 |
| Additional Coverage Offered in the Gap | 40%- 51% | \$0- \$15 and/or 40%- 51% | 40%- 51% | \$0- \$4 and/or 40%- 51% |
| Chemo Drugs | 20%/ 30% | 20% | 20% | 20% |
| Out-of-Pocket Maximum | \$6,700/ \$10,000 | \$6,700 | \$5,900 | \$3,600 |

| Summary of Benefits Table (Iberia Parish) | | |
|--|--------------------------------|--|
| Medicare Advantage Plans | AAA4 Vantage Traditional Plus | AAA8 Vantage Basic |
| Contract ID/Plan ID | H5576-008 | H5576-020 |
| Organization Name | Vantage Health Plan | Vantage Health Plan |
| Type of Medicare Plan | Local HMO | Local HMO |
| Monthly Consolidated Premium (includes part C & D) | \$32.80 | \$0 |
| Health Plan Deductible | | \$350 Out-of-network |
| PCP Co-pay | \$10 0%- 20% | \$25 or 0-20% |
| Specialist Co-pay | 20% | \$50 or 0-20% |
| ER | 20% per visit (always covered) | \$75 per visit (always covered) |
| Ambulance | 20% | \$250 |
| Skilled nursing | | \$0 for days 1 through 20 \$164 for days 21 through 100 |
| Inpatient Hospital | | \$360 for days 1 through 5 \$0 for days 6 through 90 |
| Annual Drug Deductible | \$400 | \$350 |
| Additional Coverage Offered in the Gap | 40%- 51% | 40%- 51% |
| Chemo Drugs | 20% | 20% |
| Out-of-Pocket Maximum | \$6,700 | \$6,700 |